



STATE OF TENNESSEE  
BUREAU OF TENNCARE  
DEPARTMENT OF FINANCE & ADMINISTRATION  
310 Great Circle Road  
NASHVILLE, TENNESSEE 37243

## **Instate and Out-of-State Hospital Providers**

In response to your interest in participating in the Tennessee TennCare/Medicaid Program, we are providing the necessary documents for enrollment.

Tennessee TennCare/Medicaid Providers must have completed application forms on file before claims can be processed for payment. Please complete all documents and return to:

Department of Finance and Administration  
Bureau of TennCare  
Provider Enrollment Unit  
310 Great Circle Road  
Nashville, TN 37243 - 1700

All incomplete applications and requested documents not included will be returned to the pay-to address on your application.

All documents must have original signatures.

Out-Of State Providers must return a claim form with an attached Medicare Remittance for dually-eligible Medicare/Medicaid recipients, or a claim form only if billing for a TennCare recipient.

Completed Applications will be assigned a Tennessee Medicaid Provider Number. You will be notified in writing of your assigned Provider Number. Please file all future claims only after you receive the notification as your provider number must be stated on all claim forms. Providers who have rendered a service to a TennCare only recipient will be required to enroll with the TennCare Managed Care Organization the recipient has chosen to manage his/her healthcare. The state Medicaid ID number assigned by this office should be presented to the MCO upon enrolling. You will be assigned a billing number by the MCO for reimbursement.

Should you have any questions regarding your number assignment, please contact: 1-800-342-3145, or (615) 741-6669.



STATE OF TENNESSEE  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
BUREAU OF TENNCARE  
310 GREAT CIRCLE ROAD  
NASHVILLE, TENNESSEE 37243 - 1700

## CHECKLIST

This check list will assist you in completing and returning the correct forms along with this document.  
Enrollment Packets must include the following:

### Instate And Out-Of-State Hospital Providers

Medicare Provider Number	_____
NPI Number	_____
NPI Collection Form	_____
CMS Medicare Approval Letter	_____
Hospital Accreditation	_____
State License	_____
Disclosure of Ownership	_____
(2) HIPAA Agreements	_____
No. 3 Group Application	_____
New Provider	_____
Change Of Ownership	_____
Substitute W-9 Form	_____
Claim Form (Out-Of-State Only)	_____
(2) Contracts (Instate Only)	Signed by Provider: _____

### For Office Use Only

Contracts:	Signed by Assistant Commissioner	_____
		(date)
Executed Contracts Returned to Provider		_____
		(date)
File Completed	Yes _____ No _____	_____
		(date)
		_____
		(INITIAL)

# INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

## SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All Title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

## GENERAL INSTRUCTIONS

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	-42CFR 51A.144
Title XVIII	-42CFR 420.200-206
Title XIX	-42CFR 455.100-106
Title XX	-42CFR 228.72-73

Please answer all questions as of the current date. If the “yes” space for any item is checked, list requested additional information under the Remarks Section on page 5, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original to the State agency and retain a copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State agency.

## DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

(b) **For Regional Office Use Only.** If the “yes” space is checked for Item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

### Item II - Self-explanatory.

**Item III** – List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock in the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity, (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity or the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

#### **Item IV - VII - Changes in Provider Status**

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under the applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the “yes” space is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

**Item IV - (a & b)** If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

**Item V** – If the answer is yes, list the name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

**Item VI** – If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

**Item VII** – A chain affiliate is any free-standing health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

**Item VIII** – If yes, list the actual number of beds in the facility now and the previous number.

## DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

### I. Identifying Information

Name of Entity	D/B/A	Provider #	Telephone #
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Street Address	City, County, State	Zip Code
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### II. Answer the following "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 5. Identify each item number to be continued

- A.** Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes \_\_\_\_\_ No \_\_\_\_\_

- B.** Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes \_\_\_\_\_ No \_\_\_\_\_

- C.** Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months?

Yes \_\_\_\_\_ No \_\_\_\_\_

- III. (a)** List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 5. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
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**(b)** Type of Entity:

☐ Sole Proprietorship  
☐ Corporation  
☐ Other (Specify)

☐ Partnership  
☐ Unincorporated  
Associations

- 
- (c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EIN's for corporations under Remarks.
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Check appropriate box for each of the following questions:

- (d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If "Yes", list names, addresses of individuals and provider numbers.

\_\_\_\_\_ Yes \_\_\_\_\_ No

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Name	Address	Provider Number

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- IV. (a) Has there been a change in ownership or control within the last year? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, give date: \_\_\_\_\_

- (b) Do you anticipate any change of ownership or control within the year? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, when? \_\_\_\_\_

- (c) Do you anticipate filing for bankruptcy within the year? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, when? \_\_\_\_\_

- 
- V. Is this facility operated by a management company, or leased in whole or part by another organization?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, give date of change in operations: \_\_\_\_\_

- 
- VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?

\_\_\_\_\_ Yes \_\_\_\_\_ No

- 
- VII. (a) Is this facility chain affiliated? (If Yes, list name, address of Corporation, and EIN)

\_\_\_\_\_ Yes \_\_\_\_\_ No

Name: \_\_\_\_\_ EIN # : \_\_\_\_\_

Address: \_\_\_\_\_

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**VII. (b)** If the answer to Question VII.a. is “No”, was the facility ever affiliated with a chain? \_\_\_\_\_ Yes \_\_\_\_\_ No

Name: \_\_\_\_\_ EIN # : \_\_\_\_\_

Address: \_\_\_\_\_

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**VIII** Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?

If “Yes”, give year of change: \_\_\_\_\_ Current beds: \_\_\_\_\_ Prior beds: \_\_\_\_\_

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**WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF IT’S AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.**

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Name of Authorized Representative (Typed):

Title:

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Signature:

Date:

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Remarks

## **HIPAA BUSINESS ASSOCIATE AGREEMENT**

### **IN COMPLIANCE WITH PRIVACY AND SECURITY RULES**

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (“Agreement”) is between **The State of Tennessee, Department of Finance and Administration, Bureau of TennCare (TennCare)**, 310 Great Circle Road, Nashville, TN 37243 (“Covered Entity”) and \_\_\_\_\_ (“Business Associate”), located at \_\_\_\_\_ including all office locations and other business locations at which Provider Business Associate data may be used or maintained. Covered Entity and Business Associate may be referred to herein individually as “Party” or collectively as “Parties.”

### **BACKGROUND**

Covered Entity acknowledges that it is subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

If Business Associate provides services to Covered Entity pursuant to one or more contractual relationships, said Agreements are detailed below and hereinafter referred to as “Service Agreements.”

### **LIST OF AGREEMENTS AFFECTED BY THIS Execution Date HIPAA BUSINESS ASSOCIATE AGREEMENT**

In the course of executing Service requests, Business Associate may come into contact with, use, or disclose Protected Health Information (“PHI”) (defined in Section 1 below). Said Service Agreements are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, and E, which require Covered Entity to have a written memorandum with each of its internal Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI and, therefore, execute this Agreement.



## **1. DEFINITIONS**

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.304, 164.504 and 164.501.

1.2 “Breach of the Security of the [Business Associate’s Information] System” shall mean the unauthorized acquisition, including, but not limited to, access to, use, disclosure, modification or destruction, of unencrypted computerized data that materially compromises the security, confidentiality, or integrity of personal information maintained by or on behalf of the Covered Entity under the terms of Tenn. Code Ann. § 47-18-2107 and this Agreement.

1.3 “Commercial Use” means obtaining protected health information with the intent to sell, transfer or use it for commercial, or personal gain, or malicious harm; sale to third party for consumption, resale, or processing for resale; application or conversion of data to make a profit or obtain a benefit contrary to the spirit of this Agreement, including but not limited to presentation of data or examples of data in a conference or meeting setting where the ultimate goal is to obtain or gain new business.

1.4 “Designated Record Set” shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 “Electronic Protected Health Information” (ePHI) shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.6 “Encryption” means the process using publicly known algorithms to convert plain text and other data into a form intended to protect the data from being able to be converted back to the original plain text by known technological means.

1.7 “Health Care Operations” shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.8 “Individual” shall have the same meaning as the term “individual” in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 “Marketing” means the act or process of promoting, selling, leasing or licensing any information or data for profit without the express written permission of Covered Entity.

1.10 “Privacy Officer” shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1). The Privacy officer is the official designated by a Covered Entity or Business Associate to be responsible for compliance with HIPAA regulations.

1.11 “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.12 “Protected Health Information” shall have the same meaning as the term “protected health information” in 45 CFR § 164.501, limited to the information created or

received by Business Associate from or on behalf of Covered Entity. PHI includes information in any format, including but not limited to electronic or paper.

1.13 “Required By Law” shall have the same meaning as the term “required by law” in 45 CFR § 164.501.

1.14 “Security Incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.15 “Security Event” shall mean an immediately reportable subset of security incidents which incident would include:

- a) a suspected penetration of Business Associate’s information system of which the Business Associate becomes aware but for which it is not able to verify within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS (of the time the Business Associate became aware of the suspected incident) that enrollee PHI or other confidential TennCare data was not accessed, stolen, used, disclosed, modified, or destroyed;
- b) any indication, evidence, or other security documentation that the Business Associate’s network resources, including, but not limited to, software, network routers, firewalls, database and application servers, intrusion detection systems or other security appliances, may have been damaged, modified, taken over by proxy, or otherwise compromised, for which Business Associate cannot refute the indication within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of the time the Business Associate became aware of such indication;
- c) a breach of the security of the Business Associate’s information system(s)(see definition 1.2 above), by unauthorized acquisition, including, but not limited to, access to or use, disclosure, modification or destruction, of unencrypted computerized data and which incident materially compromises the security, confidentiality, or integrity of TennCare enrollee PHI; and/or
- d) the unauthorized acquisition, including but not limited to access to or use, disclosure, modification or destruction, of unencrypted TennCare enrollee PHI or other confidential information of the Covered Entity by an employee or authorized user of Business Associate’s system(s) which materially compromises the security, confidentiality, or integrity of TennCare enrollee PHI or other confidential information of the Covered Entity.

If data acquired (including but not limited to access to or use, disclosure, modification or destruction of such data) is in encrypted format but the decryption key which would allow the decoding of the data is also taken, the parties shall treat the acquisition as a breach for purposes of determining appropriate response.

1.16 "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information" at 45 CFR Parts 160 and 164, Subparts A and C.

## **2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)**

2.1 Compliance with the Privacy Rule. Business Associate agrees to fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Agreements, or as Required By Law. In case of any conflict between this Agreement and the Service Agreements, this Agreement shall govern.

2.2 Privacy Safeguards and Policies. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Service Agreement(s), this Agreement or as Required By Law. This includes the implementation of administrative, physical, and technical safeguards to reasonably and appropriately protect the Covered Entity's PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate (See also Section 3.2). The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its workforce.

2.3 Business Associate Contracts. Business Associate shall require any agent, including a subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity, or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential TennCare information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.4 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.5 Reporting of Violations in Use and Disclosure of PHI. Business Associate agrees to require its employees, agents, and subcontractors to promptly report to Business Associate any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

2.6 Access of Individual to PHI and other Requests to Business Associate. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity in order to meet its requirements under 45 CFR § 164.524. If Business Associate receives

a request from an Individual for a copy of the individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual in a timely manner. If Business Associate receives a request for PHI not in its possession and in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall promptly forward the request to Covered Entity. Business Associate shall then assist Covered Entity as necessary in responding to the request in a timely manner. If a Business Associate provides copies of PHI to the individual, it may charge a reasonable fee for the copies as the regulations shall permit.

2.7 Requests to Covered Entity for Access to PHI. The Covered Entity shall forward to the Business Associate in a timely manner any Individual's request for access to or a copy of their PHI that shall require Business Associate's participation, after which the Business Associate shall provide access to or deliver such information as follows:

- a) The Parties understand that if either Party receives a request for access to or copies of PHI from an Individual which the Party may complete with only its own onsite information, the time for such response shall be thirty (30) days, with notification to the Covered Entity upon completion.
- b) If Covered Entity does not have the requested PHI onsite and directs Business Associate to provide access to or a copy of his/her PHI directly to the Individual, the Business associate shall have sixty (60) days from the date of the Individual's request to provide access to PHI or deliver a copy of such information to the Individual. The Business Associate shall notify the Covered Entity when it completes the response.
- c) If the Covered Entity receives a request and requires information from the Business Associate in addition to the Covered Entity's onsite information to fulfill the request, the Business Associate shall have thirty (30) days from date of Covered Entity's notice to provide access or deliver such information to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day requirement of 45 CFR § 164.524.
- d) If the Party designated above responding to the Individual's request is unable to complete the response to the request in the time provided, that Party shall provide the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Party may extend the response time once for no more than thirty (30) additional days.

2.8 Individuals' Request to Amend PHI. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, regarding an Individual's request to amend PHI. The Business Associate shall make the amendment promptly in the time and manner designated by Covered Entity, but shall have thirty (30) days notice from Covered Entity to complete the amendment to the Individual's PHI and to notify the Covered Entity upon completion.

2.9 Recording of Designated Disclosures of PHI. Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

2.10 Accounting for Disclosures of PHI. The Business Associate agrees to provide to Covered Entity or to an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. The Covered Entity shall forward the Individual's request requiring the participation of the Business Associate to the Business Associate in a timely manner, after which the Business Associate shall provide such information as follows:

- a) If Covered Entity directs Business Associate to provide accounting of disclosures of the Individual's PHI directly to the Individual, the Business Associate shall have sixty (60) days from the date of the Individual's request to provide access to or deliver such information to the Individual. The Covered Entity shall provide notice to the Business Associate in time to allow the Business Associate a minimum of thirty (30) days to timely complete the Individual's request.
- b) If the Covered Entity elects to provide the accounting to the Individual, the Business Associate shall have thirty (30) days from date of Covered Entity's notice of request to provide information for the Accounting to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day period.
- c) If either of the Parties is unable to complete the response to the request in the times provided above, that Party shall notify the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Parties may extend the response time once for no more than thirty (30) additional days.
- d) The accounting of disclosures shall include at least the following information: (1) date of the disclosure; (2) name of the third party to whom the PHI was disclosed, (3) if known, the address of the third party; (4) brief description of the disclosed information; and (5) brief explanation of the purpose and basis for such disclosure.
- e) The Parties shall provide one (1) accounting in any twelve (12) months to the Individual without charge. The Parties may charge a reasonable, cost-based fee, for each subsequent request for an accounting by the same Individual if he/she is provided notice and the opportunity to modify his/her request. Such charges shall not exceed any applicable State statutes or rules.

2.11 Minimum Necessary. Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.11.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.11.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.11.3 Business Associate agrees to adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity

2.12 Privacy Compliance Review upon Request. Business Associate agrees to make its internal practices, books and records, including policies, procedures, and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of Covered Entity available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.13 Cooperation in Privacy Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Privacy Rule.

### **3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)**

3.1 Compliance with Security Rule. Business Associate agrees to fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Security Safeguards and Policies. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation of its compliance with the Security Rule.

3.3 Security Provisions in Business Associate Contracts. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI

received from, maintained, or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, shall execute a bilateral contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, incorporating the same restrictions and conditions in this Agreement with Business Associate regarding PHI.

3.4 Tennessee Consumer Notice of System Breach. Business Associate understands that the Covered Entity is an “information holder” (as may be Business Associate) under the terms of Tenn. Code Ann. § 47-18-2107, and that in the event of a breach of the Business Associate’s security system as defined by that statute and Definition 1.2 of this agreement, the Business Associate shall indemnify and hold the Covered Entity harmless for expenses and/or damages related to the breach. Such obligation shall include, but is not limited to, the mailed notification to any Tennessee resident whose personal information is reasonably believed to have been acquired by an unauthorized individual. In the event that the Business Associate discovers circumstances requiring notification of more than one thousand (1,000) persons at one time, the person shall also notify, without unreasonable delay, all consumer reporting agencies and credit bureaus that compile and maintain files on consumers on a nationwide basis, as defined by 15 U.S.C. § 1681a, of the timing, distribution and content of the notices. Substitute notice, as defined by Tenn. Code Ann. § 47-18-2107(e)(2) and (3), shall not be permitted except as approved in writing in advance by the Covered Entity. The parties agree that PHI includes data elements in addition to those included by “personal information” under Tenn. Code Ann. § 47-18-2107, and agree that Business Associate’s responsibilities under this paragraph shall include all PHI.

3.5 Reporting of Security Incidents. The Business Associate shall track all security incidents as defined by HIPAA and shall periodically report such security incidents in summary fashion as may be requested by the Covered Entity, but not less than annually within sixty (60) days of the anniversary of this Agreement. The Covered Entity shall not consider as security incidents, for the purpose of reporting, external activities (port enumeration, etc.) typically associated with the “footprinting” of a computing environment as long as such activities have only identified but not compromised the logical network perimeter, including but not limited to externally facing firewalls and web servers. The Business Associate shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for Business Associate’s operations. However, the Business Associate shall expediently notify the Covered Entity’s Privacy Officer of any Security Incident which would constitute a Security Event as defined by this Agreement, including any “breach of the security of the system” under Tenn Code Ann. § 47-18-2107, within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of any unauthorized acquisition including but not limited to use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware. The Business Associate shall likewise notify the Covered Entity within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

3.5.1 Business Associate shall identify in writing key contact persons for administration, data processing, Marketing, Information Systems and Audit Reporting

within thirty (30) days of execution of this Agreement. Business Associate shall notify Covered Entity of any reduction of in-house staff persons during the term of this Agreement in writing within ten (10) business days.

3.6 Contact for Security Event Notice. Notification for the purposes of Sections 2.5, 3.4 and 3.5 shall be in writing made by certified mail or overnight parcel within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

Privacy Officer  
Bureau of TennCare  
310 Great Circle Rd.  
Nashville Tennessee  
Phone: (615) 507-6855  
Facsimile: (615) 532-7322

3.7 Security Compliance Review upon Request. Business Associate agrees to make its internal practices, books, and records, including policies and procedures relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of Covered Entity, available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.8 Cooperation in Security Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Security Rule.

#### **4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE**

4.1 Use of PHI for Operations on Behalf of Covered Entity. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services (i.e., treatment, payment or health care operations) for, or on behalf of, Covered Entity as specified in Service Agreements, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Other Uses of PHI. Except as otherwise limited in this Agreement, Business Associate may use PHI within its workforce as required for Business Associate's proper management and administration, not to include Marketing or Commercial Use, or to carry out the legal responsibilities of the Business Associate.

4.3 Third Party Disclosure Confidentiality. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or, if permitted by law, this Agreement, and the Service Agreement, provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business



Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached within FORTY-EIGHT (48) HOURS or no more than TWO (2) BUSINESS DAYS of event.

4.4 Data Aggregation Services. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation Services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(I)(B).

4.5 Other Uses Strictly Limited. Nothing in this Agreement shall permit the Business Associate to share PHI with Business Associate's affiliates or contractors except for the purposes of the Service Agreement(s) between the Covered Entity and Business Associate(s) identified in the "LIST OF AGREEMENTS AFFECTED BY THIS [BUSINESS ASSOCIATE] AGREEMENT & HIPAA REQUIREMENTS" on page one of this Agreement.

4.6 Covered Entity Authorization for Additional Uses. Any use of PHI or other confidential TennCare information by Business Associate, its affiliate or Contractor, other than those purposes of this Agreement, shall require express written authorization by the Covered Entity, and a Business Associate agreement or amendment as necessary. Activities which are prohibited include, but not are not limited to, Marketing, as defined by 45 CFR § 164.503 or the sharing for Commercial Use or any purpose construed by Covered Entity as Marketing or Commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws.

4.7 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Business Associate to share, use or disclose PHI in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the Covered Entity.

4.8 Data Use Agreement - Use and Disclosure of Limited Data Set. Business Associate may use and disclose a Limited Data Set that Business Associate creates for Research, public health activity, or Health Care Operations, provided that Business Associate complies with the obligations below. Business Associate may not make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of this Agreement.

4.9 Limitation on Permitted Uses and Disclosures. Business Associate will limit the uses and disclosures it makes of the Limited Data Set to the following: Research, public health activity, or Health Care Operations, to the extent such activities are related to covered functions, including business planning and development such as conducting cost-management and planning-related analysis related to managing and operating Business Associates functions, formulary development and administration, development and improvement of methods of payment or coverage policies, customer service, including the provision of data analysis for policy holders, plan sponsors, or other customers, to the

extent such activities are related to covered functions, provided that PHI is not disclosed and disclosure is not prohibited pursuant to any other provisions in this Agreement related to Marketing or Commercial use.

## **5. OBLIGATIONS OF COVERED ENTITY**

5.1 Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of Privacy Practices produced by Covered Entity in accordance with 45 CFR § 164.520, as well as any changes to such notice.

5.2 Notice of Changes in Individual's Access or PHI. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Notice of Restriction in Individual's Access or PHI. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

5.4 Reciprocity for Requests Received by Business Associate. The Parties agree that this Section (Section 5) is reciprocal to the extent Business Associate is notified or receives an inquiry from any individual within Covered Entity's covered population.

## **6. PERMISSIBLE REQUESTS BY COVERED ENTITY**

6.1 Requests Permissible under HIPAA. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule.

## **7. TERM AND TERMINATION**

7.1 Term. This Agreement shall be effective as of the date on which it has been signed by both parties and shall terminate when all PHI which has been provided, regardless of form, by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if the Parties agree that it is unfeasible to return or destroy PHI, subsection 7.3.5 below shall apply.

7.2 Termination for Cause. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Agreement in the event Business Associate fails to comply with, or violates a material provision of this Agreement and any provision of the Privacy and Security Rules.

7.2.1 Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

- a) Provide notice of breach and an opportunity for Business Associate to reasonably and promptly cure the breach or end the violation, and terminate this BAA if Business Associate does not cure the breach or end the violation within the reasonable time specified by Covered Entity; or
- b) Immediately terminate this BAA if Business Associate has breached a material term of this BAA and cure is not possible; or
- c) If termination, cure, or end of violation is not feasible, Covered Entity shall report the violation to the Secretary.

7.3 Effect of Termination. Upon termination of this Agreement for any reason, except as provided in subsections 7.3.2 and 7.3.5 below, Business Associate shall at its own expense either return and/or destroy all PHI and other confidential information received, from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Business Associate.

7.3.1 The Business Associate shall consult with the Covered Entity as necessary to assure an appropriate means of return and/or destruction and shall notify the Covered Entity in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by the Covered Entity.

7.3.2 This provision (Section 7.3 and its subsections) shall not prohibit the retention of a single separate, archived file of the PHI and other confidential TennCare information by the Business Associate if the method of such archiving reasonably protects the continued privacy and security of such information and the Business Associate obtains written approval at such time from the Covered Entity. Otherwise, neither the Business Associate nor its subcontractors and agents shall retain copies of TennCare confidential information, including enrollee PHI, except as provided herein in subsection 7.3.5.

7.3.3 The Parties agree to anticipate the return and/or the destruction of PHI and other TennCare confidential information, and understand that removal of the confidential information from Business Associate's information system(s) and premises will be expected in almost all circumstances. The Business Associate shall notify the Covered Entity whether it intends to return and/or destroy the confidential with such additional detail as requested. In the event Business Associate determines that returning or destroying the PHI and other confidential information received by or created for the Covered Entity at the end or other termination of the Service Agreement is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible.

7.3.4 Except for Business Associate Agreements in effect prior to April 21, 2005 when the Security Rule became effective, for the renewal or amendment of those same

Agreements, or for other unavoidable circumstances, the Parties contemplate that PHI and other confidential information of the Covered Entity shall not be merged or aggregated with data from sources unrelated to that Agreement, or Business Associate's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of the TennCare data or other confidential information of the Covered Entity at the conclusion of the Service Agreement, or otherwise make an express alternate agreement consistent with the provisions of Section 7.3 and its subsections.

7.3.5 Upon written mutual agreement of the Parties that return or destruction of PHI is unfeasible and upon express agreement as to the means of continued protection of the data, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

## **8. MISCELLANEOUS**

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and/or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3 of this Agreement shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Headings. Paragraph Headings are used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

8.6 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address, telephone number, fax numbers

and to promptly supplement this Agreement as necessary with corrected information.  
**Notifications relative to Sections 2.5, 3.4 and 3.5 of this Agreement must be reported to the Privacy Officer pursuant to Section 3.6.**

COVERED ENTITY:

BUSINESS ASSOCIATE:

Darin Gordon	_____
Director	_____
Department of Finance and Adm.	_____
Bureau of TennCare	_____
310 Great Circle Road	_____
Nashville, TN 37243	_____
(615) 507-6443	_____
Fax: (615) 253-5607	Fax: _____

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.7 **Strict Compliance.** No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

8.8 **Severability.** With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.9 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement and the Service Agreement (s).

8.10 **Compensation.** There shall be no remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative

requirements of Tennessee State government and Services Agreement(s) referenced herein.

**IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:**

**BUREAU OF TENNCARE**

**BUSINESS ASSOCIATE**

By: \_\_\_\_\_

By: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

***Darin J. Gordon, Director***

State of Tennessee, Dept of Finance & Adm.

310 Great Circle Road

Nashville, Tennessee

Phone: (615) 507-6443

Fax: (615) 253-5607

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_



**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION**  
**NO. 3 GROUP APPLICATION**  
[www.state.tn.us/tenncare/Providers/enroll.html](http://www.state.tn.us/tenncare/Providers/enroll.html)

<b>(Check All That Apply)</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> MCC Medicaid No. <input type="checkbox"/> Medicare/Medicaid No.		<input type="checkbox"/> Change of Ownership <input type="checkbox"/> Reactivation <input type="checkbox"/> Adding Practice/Satellite Location <input type="checkbox"/> Name Change and Tax ID # Change
<b>Indicate Provider Type (Check One)</b>		
<input type="checkbox"/> Clinic <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital: <input type="checkbox"/> Acute <input type="checkbox"/> Critical Access <input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Group <input type="checkbox"/> Independent Lab <input type="checkbox"/> Ambulatory Surgical Ctr. <input type="checkbox"/> DME Supplier <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Rural Health Clinic	<input type="checkbox"/> X-Ray Clinic <input type="checkbox"/> Nursing Homes: <input type="checkbox"/> ICF <input type="checkbox"/> SNF <input type="checkbox"/> ICF/MR <input type="checkbox"/> Other _____

Legal Business Name: \_\_\_\_\_

D/B/A: \_\_\_\_\_

Practice Location: \_\_\_\_\_  
( No P.O. Box # )

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code + 4: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ County: \_\_\_\_\_

If the name and address to which checks and remittance advices are to be sent is different from the name and address above, please provide that information below. This pay-to information should match the W-9 form.

Legal Business Name as reported to the IRS: \_\_\_\_\_

Street Address or P.O. Box: \_\_\_\_\_  
(Pay-To Address)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code + 4: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Federal Tax No. (IRS No.): \_\_\_\_\_ DEA No.: \_\_\_\_\_

Applying For: Part A \_\_\_\_\_ Part B \_\_\_\_\_

Medical Specialty: \_\_\_\_\_

Briefly describe the services you propose to offer to Medicaid recipients: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical supplies and durable medical equipment only — briefly describe the types of items and equipment you propose to supply to Medicaid recipients:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Federal Medicare No.: \_\_\_\_\_ State Medicaid No.: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Taxonomy: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Submit copies of professional and/or business licenses, accreditations, certifications, and registrations specifically required to operate as a health care provider.

Date of Issuance: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes \_\_\_\_ No \_\_\_\_.** **If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.**

Please list the full name of every owner, with Social Security number and percent of ownership (**required**). If owned by corporation, please list corporate officers with same information. Use additional paper if necessary.

Name	Title	SSN	% Ownership
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

**EFFECTIVE DATE FOR OPENING/REOPENING OFFICE:** \_\_\_\_\_

**EFFECTIVE DATE OF CHANGE OF OWNERSHIP:** \_\_\_\_\_

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any): \_\_\_\_\_

Previous Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code + 4: \_\_\_\_\_

**IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.**

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Original Signature of Administrator, Agent, or Owner)

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_



**SUBSTITUTE W-9 FORM**  
**REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION**

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**1. Please complete general information:**

Taxpayer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Business Name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

---

**2. Circle the most appropriate category below: (please circle only one)**

- 1) Individual (not an actual business)
  - 2) Joint account (two or more individuals)
  - 3) Custodian account of a minor
  - 4)
    - a. Revocable savings trust (grantor is also trustee)
    - b. So-called trust account that is not a legal or valid trust under state law
  - 5) Sole proprietorship (using a social security number for the taxpayer ID)
  - 6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
  - 7) A valid trust, estate, or pension trust
  - 8) Corporation
  - 9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
  - 10) Partnership
  - 11) A broker or registered nominee
  - 12) Account with the U.S. Department of Agriculture in the name of a public entity that receives agricultural program payments
  - 13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)
- 

**3. Fill in your taxpayer identification number below: (please complete only one)**

- 1) If you circled number 1-5 above, fill in your Social Security Number

\_\_ \_\_ \_\_ - \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

- 2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

\_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

---

**Sign and date the form:**

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title (if applicable): \_\_\_\_\_



STATE OF TENNESSEE  
THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION  
MEDICAL ASSISTANCE PARTICIPATION AGREEMENT  
(MEDICAID / TENNCARE TITLE XIX PROGRAM)  
FOR  
INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Name of Hospital : \_\_\_\_\_  
Address : \_\_\_\_\_  
Hospital License No. : \_\_\_\_\_ Medicaid Provider No.: \_\_\_\_\_

This agreement and working contract, entered into the \_\_\_\_\_ day of \_\_\_\_\_,  
\_\_\_\_\_, between the Tennessee Department of Finance and Administration,  
hereinafter referred to as "the Department" and

---

(Name of Hospital)

(City and State)

(Zip Code)

an institution for providing inpatient and outpatient hospital services and other  
supportive patient services for which it is currently licensed and certified, hereinafter  
referred as "the Facility".

I. The Facility Agrees :

- A. To participate in the Tennessee Medicaid/TennCare program by providing major medical and surgical and/or acute short term care in return for considerations received from the Department.
- B. To remain licensed under the laws of the State of Tennessee and fully meet other minimum standards for participation as follows :
  - 1. To remain fully certified for participation in Medicare;
  - 2. To meet all health and safety requirements or have a written plan of improvement that will meet all requirements for approval by the Health Care Facilities Licensing Division of the Department.
- C. To maintain accounting records that will enable the Facility to comply with "Principles of Reimbursement for Provider Costs HIM5 (revised 1-67) SSA.

- D. To comply with the policies and procedures prescribed or required by the Department in the administration of the Medical Assistance Program.
- E. To abide by all laws, regulations, policies and procedures applicable to services rendered under Medicaid/TennCare Title XIX Program.
- F. To render the same quality of service to Medicaid recipients as rendered to private patients.
- G. To maintain the Outpatient Department as an integral part of the FACILITY and as such licensed under the laws of Tennessee.
- H. To complete the necessary treatment and discharge recipients from the Facility in the minimum number of days consistent with good medical practices as determined by an active utilization review committee, or PSRO, when under binding review.
- I. To provide services to eligible Medicaid/TennCare recipients and comply with the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 which prohibit a participating provider or vendor of services from making a distinction on the basis of race, color, national origin or handicap.
- J. To render services to be paid under Medicaid/TennCare Title XIX Program, only to holders of valid recipient Identification (ID) Cards upon presentation and proper identification.
- K. To submit to the designated fiscal agent for reimbursement only those items of authorized hospital services that are actually provided to eligible recipients under the Medical Assistance Program (Title XIX).
- L. That payment made to the Facility by the Department or its agent under this program will be accepted as payment in full for the care of the patient and that no additional charge will be made to the patient, any member of his family, or responsible agent.
- M. To apply as a credit against the total reimbursable amount any hospitalization insurance or any other third party payment applicable to the period for which the state assumes responsibility, said period to be construed as beginning on the date of authorized admission of the individual patient.
- N. To accept the same method of reimbursement for Title XIX services that is used for reimbursement of Title XVIII, Medicare services.
- O. To have a desk review and audit after each fiscal year end, as may be required, with an appropriate adjustment. If there has been a payment in excess of "reasonable costs" during the audit period, the Facility agrees to refund the excess payment.

- P. To make pertinent medical information available to authorized representatives of the Department subject to appropriate legal, ethical and professional considerations.
- Q. To make available to the Department or its representative, the necessary fiscal records, including audit reports and work papers prepared by Part A Medicare fiscal intermediary auditors, for the Title XIX retroactive adjustments.
- R. To keep any records necessary to disclose the extent of services the provider furnishes to recipients.
- S. To make available on request of the Department, the Secretary of the State Medicaid/TennCare fraud control unit any information contained in the records including information regarding payments claimed by the provider for furnishing services under the plan.
- T. To disclose to the Department the identity of any person who has ownership or control interest in the Facility, or is an agent or managing employee of the Facility.
- U. To disclose to the Department the name and address of each person with an ownership or control interest in the disclosing entity or in a subcontractor in which the disclosing entity has a direct or indirect ownership interest of five (5) percent or more.
- V. To inform the Department if any person(s) named, in compliance with I.U, above is related to another as a spouse, parent, child or sibling.
- W. To name any other disclosing entity in which a person(s) with an ownership or control interest in the disclosing facility also has an ownership or control interest. This applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person.
- X. To keep copies of all requests and the responses to them in accordance with I. W. above, and to make them available to the Secretary or the Department on request, and to advise the Medicaid/TennCare agency when there is no response to a request.
- Y. To submit within thirty-five (35) days of the date of a request by the Secretary or the Department full and complete information about :
  - 1. The ownership or any subcontractor with whom the provider has had business transactions totaling more than \$ 25,000.00 during the twelve (12) month period ending on the date of the request;
  - 2. Any significant business transactions between the provider and any wholly owned supplier, or between the facility and the subcontractor during the five (5) year period ending on the date of the request.

- Z. To furnish updated information to the Secretary or the State Survey Agency or Medicaid/TennCare agency at intervals between recertification or contract renewals within thirty-five (35) days of a written request.
- A1. To disclose to the Department the identity of any person in accordance with I. T. above that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid/TennCare, or the Title XIX services program since the inception of those programs.

## II. The Department Agrees :

- A. To give the Facility reasonable notice of any impending change in its status as an Inpatient and Outpatient Hospital provider.
- B. To notify the Facility of any major changes in Title XIX Rules and Regulations, and to work with the Facility with the view toward providing the best medical care available within the limitations of the law and available money.

## III. MEDICAID/TENNCARE and the FACILITY Agree :

- A. That payments to the Facility may be withheld, if necessary, because of irregularity from whatever cause, until such irregularity or difference can be adjusted.
- B. That proper adjustments in vendor payments will be made (as indicated to compensate for either overpayment or underpayment).
- C. That if any part of this agreement is found to be in conflict with any Federal or State law or regulation, having equal weight of law, or if any part is placed in conflict by amending of such law, this agreement is so amended.
- D. That Tennessee Code Annotated, Chapter 19, Section 14-1923, is made part of this agreement and quoted as follows :

"Any individual or corporate vendors or provider participating under the provisions of this chapter who holds an equity interest in any hospital, apothecary, nursing home, or other vendor or provider participating under the provisions of this chapter shall submit annually to the Department of Finance and Administration information disclosing their interest in these vendors and providers. Any such party who fails to file the information required by this section shall not be entitled to participate in the program."

- E. That the effective date for vendor payments will be the date the Facility attains participating status as determined by the Department and that such determination shall be made a part of this agreement.
- F. That by signing this agreement, the Facility and the Department accept all of the stipulations in the agreement and agree to each and every provision herein. The parties further agree that any failure on the part of either to comply

with any of the provisions set out above shall be considered a breach of this contract and that such contract shall be subject to immediate cancellation.

- G. That the Department or Facility may cancel this agreement by providing the other party with written notice.

### **Confidentiality of Records.**

Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit the Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

### **HIPAA Compliance.**

Contractor warrants to the State that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this contract. Contractor warrants that it will cooperate with the State in the course of performance of the contract so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep the State and Contractor in compliance with HIPAA, including but not limited to business associate agreements.

### **TBI MFCU Access to Contractor and Provider Records Program Integrity Access to Contractor, Provider, and Enrollee Records.**

Pursuant to Executive Order 47 and 42 C.F.R. § 1007, the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud, abuse, and neglect in the State Medicaid program (TennCare).

Program Integrity assists TBI MFCU with provider cases and has the primary responsibility to investigate TennCare enrollee fraud and abuse.

The Contractor shall immediately report to the TBI MFCU any known or suspected fraud, abuse, waste and/or neglect, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return monies allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing the TBI MFCU, and must cooperate fully in any investigation by the TBI MFCU or subsequent legal action that may result from such an investigation.

The Contractor and all its health care providers, whether participating or non-participating providers, shall, upon request, make available to the TBI MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU must be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, whether participating or non-participating, during normal business hours, except under special circumstances when after hour admission shall be allowed. The TBI MFCU shall determine any and all special circumstances.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, TBI MFCU is a health oversight agency. See 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. In its capacity as a health oversight agency, TBI MFCU does not need authorization in order to obtain enrollee protected health information (PHI). PHI is defined at 45 C.F.R. § 164.501. Because MFCU will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to those disclosures to TBI MFCU that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d) and 65 F.R. §§ 82462 and 82673.

The Contractor shall inform its participating and non-participating providers that as a condition of receiving any amount of TennCare payment, the provider must comply with this Section of this Contract regarding fraud, abuse, waste and neglect.

The Contractor and its participating and non-participating providers shall report TennCare enrollee fraud and abuse to Program Integrity. The Contractor and/or provider may be asked to help and assist in investigations by providing requested information and access to records. The Contractor and its health care providers, whether participating or non-participating providers, shall, upon request, make available any and all supporting documentation/records relating to delivery of items or services for which TennCare monies are expended. Shall the need arise, Program Integrity must be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours.

**Debarment and Suspension.**

To the best of its knowledge and belief, the Contractor certifies by its signature to this Contract that the Contractor and its principals :

- A. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or Contractor;
- B. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- C. are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and
- D. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, State, or Local) terminated for cause or default.

This contract shall take effect on the date of the on site health and safety survey if all federal requirements are met, if all requirements are met, or the date the provider submits an acceptable plan of correction or waiver request.

Tennessee Department of Finance and Administration

By : \_\_\_\_\_  
Signature of Administrator Date

\_\_\_\_\_  
Name of Hospital

By : \_\_\_\_\_  
Assistant Commissioner Date



**National Provider Identifier (NPI) Collection Form  
(Individual/ Solo Practices)**

Any form not containing all required fields will be rejected.

**Section 1 – Provider General Information  
(Please make additional copies if required)**

Provider Last Name	First Name	Middle	Title
Existing Medicaid ID's	SSN		EIN Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Section 2 – NPI Information**

NPI Number _____		
Taxonomy Codes		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Section 3 – Primary Practice Location (As Entered on NPPES)**

Address _____		
_____	_____	_____
City	State	ZIP
_____	_____	_____
Phone Number	Fax Number	Provider e-mail Address

**Section 4 – Contact Information**

Name of Individual Completing Form _____		
_____	_____	_____
Phone Number	Fax Number	Contact e-mail Address

Signature _____	Title _____
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**NPI Collection Form Surety Statement:**

**“I certify that the information provided on this application is complete and correct to the best of my knowledge.”**

## Instructions Individual/Solo Practice

Send the completed NPI Collection Form and a copy of the NPPES confirmation via one of the following means:

<b>Mail</b>	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
<b>Fax</b>	(615) 248-4386 or (866) 456-8059
<b>Field</b>	<b>Instruction</b>
<b>Section 1 – Provider General Information</b>	
Provider Last Name	(Required) Enter the provider's last name.
First Name	(Required) Enter the provider's first name.
Middle	(Optional) Enter the provider's middle name.
Title	(Required) Enter the provider's title.
Existing Medicaid ID's	(Required) Enter all currently assigned Medicaid provider numbers.
SSN	(Required) for an individual provider. Enter the Social Security Number.
EIN Number	(Required) Enter the Employer Identification Number (could be SSN).
<b>Section 2 – NPI Information</b>	
National Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
<b>Section 3 – Primary Practice Location</b>	
Address	(Required) Enter the primary practice location line 1 address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location ZIP of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider e-mail Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
<b>Section 4 – Contact Information</b>	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact e-mail Address	(Optional) Enter the e-mail address of the individual completing this form.
Signature and Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.

# National Provider Identifier (NPI) Collection Form (Group Practices)

Any form not containing all required fields will be rejected.

## Section 1 – Provider General Information

Business Name	_____		
Doing Business As (Name)	_____		
_____	_____	_____	
Medicaid ID	EIN	NPI	
Taxonomy Codes	_____	_____	_____
	_____	_____	_____

## Section 2 – NPI Information

(Please Complete this Section for each Individual Provider that is associated with your Group. Please Make additional copies if required)

Provider Name	Medicaid ID	NPI	SSN	Taxonomy	Taxonomy

## Section 3 – Primary Practice Location (As Entered on NPPES)

Address	_____		
	_____	_____	_____
	City	State	ZIP
_____	_____	_____	
Phone Number	Fax Number	Provider Email Address	

## Section 4 – Contact Information

Name of Individual Completing Form	_____		
_____	_____	_____	
Phone Number	Fax Number	Contact Email Address	

Signature	Title
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### NPI Collection Form Surety Statement:

“I certify that the information provided on this application is complete and correct to the best of my knowledge.”

# Instructions Group Practices

Send the completed NPI Collection Form via one of the following means:

<b>Mail</b>	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
<b>Fax</b>	(615) 741-0028
<b>Field</b>	<b>Instruction</b>
<b>Section 1 – Provider General Information and NPI Information</b>	
Provider Business Name	(Required) Enter the provider's name (Facilities, Agencies, Groups, Hospitals, etc.).
D/B/A Name	(Required If Applicable).
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
EIN	(Required for a business entity) Enter the Employer Identification Number.
National Provider Identification Number	(Required) Enter the National Plan and Provider Enumeration System (NPPEs) assigned NPI.
<b>Section 2 – Group Member - NPI Information</b>	
Provider Name	(Required) Enter the individual provider name linked to this group number.
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
NPI Individual Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPEs) assigned NPI.
Social Security Number	(Required) Enter the Individual Provider SSN.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
<b>Section 3 – Primary Practice Location</b>	
Address	(Required) Enter the primary practice location address of the provider as entered in the NPPEs.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPEs.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPEs.
ZIP	(Required) Enter the primary practice location zip of the provider as entered in the NPPEs. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPEs.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPEs.
Provider Email Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPEs.
<b>Section 4 – Contact Information</b>	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact Email Address	(Optional) Enter the email address of the individual completing this form.
Signature/Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.